

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049278

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 352

Primary Registration District No. 4517

Registrar's No. 114

STATE FILE NUMBER

VS 300
Rev. 4/59

1060

21060

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9593X

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Taneyb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN BransonLength of stay in 1b
1 dayc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Skaggs Hosp.Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Taney

c. CITY OR TOWN Branson

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
310 Com.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print) First Middle Last
WILLIAM ARTHUR SAILER4. DATE OF DEATH Month Day Year
Dec. 8, 19625. SEX
M6. COLOR OR RACE
W7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
9/9/18869. AGE (last birthday)
7610. IF UNDER 1 YEAR
Months Days Hours Min.
2 2910a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired10b. KIND OF BUSINESS OR INDUSTRY
Bridgeman11. BIRTHPLACE (City and state or country)
Kansas12. CITIZEN OF WHAT COUNTRY
USA13a. FATHER'S NAME
John Sailer13b. MOTHER'S MAIDEN NAME
Agnes Quednow14. NAME OF HUSBAND OR WIFE
May Sailer15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
yes yes WWI16. SOCIAL SECURITY NO.
[redacted]17. INFORMANT
Mrs May Sailer Branson, Mo18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

septicemia
septicemia

INTERVAL BETWEEN ONSET AND DEATH

5 days
6 mosConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Dec 7 3:30 P.M. to Dec 8 and last saw him alive on Dec 8
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)
burial23b. DATE
12/12/6223c. NAME OF CEMETERY OR CREMATORY
National Cemetery23d. LOCATION (City, town, or county)
Springfield, Mo

(State)

24. FUNERAL DIRECTOR

ADDRESS

Walter Cobb Branson, Mo

25. DATE RECD. BY LOCAL REG.

12-15-62

26. REGISTRAR'S SIGNATURE

Helen Campbell

DEC 26 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Walter Post

Licensed Embalmer No. 4731

P. O. Address Brown mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.